TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Stephenville

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-17-1166-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $5,417.34 less their previous payment of $2,283.78., which leaves an outstanding balance of $3,133.46."

Amount in Dispute: $3,133.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid $2,283.78. An additional payment of $31.86 is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2016	Outpatient Hospital Services	$3,133,56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 370 – The hospital outpatient allowance was calculated according to the APC rate plus a markup

- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 619 – The procedure/supply was not sufficiently identified and/or quantified
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate
- 746 – Routine drug/alcohol tests for emplyr & as part of emplyr policy are not medical necessary for the treatment of the compensable injury
- 767 – Paid per O/P FG at 200%: Implants not applicable or separate reimbursement (with cert) no requested per Rule 134.403(G)
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal

Issues

1. What is the applicable rule that applies to outlier calculations for outpatient hospital services?

Findings

The requestor is seeking reimbursement of $3,133.56 for outpatient hospital services rendered on January 9, 2016. The requestor states, "Per the TDI/DWC fee schedule this account qualifies for an Outlier payment…"

Outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The Medicare payment policy found in the Medicare claims processing manual, Chapter 4, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf states,

The current outlier payment is determined by:

> *• Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass- through status to payment for the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and*
>
> *• Determining whether the total cost for a service exceeds 1.75 times the OPPS payment **and** separately exceeds the fixed-dollar threshold determined each year;*

For 2016 outlier payment thresholds is found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9486.pdf which states in pertinent part,

> *17 c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2016. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments*
>
> *17 d. The fixed-dollar threshold increases in CY2016 relative to CY 2015. The estimated cost of service must be greater than the APC payment amount plus $3,250 in order to qualify for outlier payments*.

The outlier calculation on the submitted charges is as follows:

1. The applicable APC/status indicator for each service line at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.
    - Procedure code 36415, 80053, 85025, 81001 has status indicator Q4 denoting conditionally packaged laboratory services. Not separately payable.
    - Procedure code G0480 not found under applicable OPPS to have APC. Not separately payable.
    - Procedure code 71010. This service is under **APC 5521.**
    - Procedure code 72170 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date but as composite APC described below is "S," this line is packaged.
    - Procedure code 72125, 74177, 70450, and 71260 have status indicator Q3 denoting packaged codes paid through a composite APC. These services have status indicator "S" and **APC 8006**.
    - Procedure code 76376 has status indicator N denoting packaged codes with no separate payment; reimbursement packaged with payment for other services (including outliers).
    - Procedure code 99284 has status indicator J2 and is under **APC 5024**.
    - Procedure code Q9967 has status indicator N denoting packaged codes with no separate payment; reimbursement packaged with payment for other services (including outliers).
2. Determine the Medicare APC payment amount at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.
    - APC 5024 has a payment amount of $326.99
    - APC 8006 has a payment amount of $493.91
    - APC 5521 has a payment amount of $60.80

    Total $881.70
3. To establish the estimated cost of service, calculate the proportional amount of packaged costs allocated to each separately paid APC based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim:
    - For APC 5024, percent of payment or: $326.99/$881.70 = .37 Total packaged costs x percent of payment rate or: $18,751.11 x .37 = $6,937.91
    - For APC 8006, percent of payment or: $493.91/$881.70 = .56 Total packaged costs x percent of payment rate or: $18,751.11 x .56 = $10,500.62
    - For APC 5521, percent of payment or: $60.80/$881.70 = .07 Total packaged costs x percent of payment rate or: $18,751.11 x .07 = $1,312.58

APC	**Estimated cost** of service x 2016 Cost to Charge (0.198) rationale for facility	**Line – Item APC payment x 1.75**	**2016 Fixed -dollar threshold plus APC**
5024	$6,937.91 x 0.198 = $1,373.71	$326.99 x 1.75 = $572.23	$3,250 + $326.99 = $3,576.99
8006	$10,500.62 x 0.198 = $2,079.12	$493.91 x 1.75 = $864.34	$3,250 +493.91 = $3,743.91
5521	$1,312.58 x 0.198 = $259.89	$60.80 x 1.75 = $106.40	$3,250 + $60.80 = $3,310.80

Based on the above calculations for each service line, none of the service lines cost exceeds ***both*** 1.75 times the OPPS payment and the fixed dollar threshold ($3,250) for 2016 plus the APC payment amount.

Therefore, the Division determines the requestor's position of "this account qualifies for an Outlier payment" is not supported. No additional payment recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.